# A Decision Making Approach to Comprehensive Health Planning

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AS A RESULT of a series of activities and research studies aimed at understanding the concepts and dynamics of community health planning, the Community Action Studies Project (CASP) of the National Commission on Community Health Services (NCCHS) offered a major recommendation regarding adoption of an "action-planning" concept (*1*):

> The nature of today's society and the complexities of health and other community services require a broad approach to planning and action which can be fitted to each particular community situation, yet is in harmony with broader trends and is capable of further development and change. Planning is an action process and is basic to development and maintenance of quality community health services. Action-planning for health should be community-wide in area, continuous in nature, comprehensive in scope, all-inclusive in design, coordinative in function, and adequately staffed.

Hence, we might conclude that planning (or action-planning) has achieved a high degree of consensus, at least in principle, within leadership structures in the health field and among most of the people involved in community health activities. Considerable confusion exists, however, about what planning for health services actually is.

A review of health planning literature, even the reports published as a result of NCCHS studies, reveals few specific definitions of planning and its particular relationship to the task of improving the public's health. In the previously cited CASP report (*1*), we in the project enumerated the dimensions that we considered especially important in action-planning; that is, to have an action-planning mechanism, that it represents the total community (in the regional sense of the word), that it operates continuously, that its subject matter is comprehensive, that it is inclusive in order to deal with the interrelatedness of various health and nonhealth concerns, and that its function is coordinative in order to overcome fragmentation of responsibility and programing.

A recent policy statement by an American Public Health Association subcommittee on comprehensive health planning likewise provides guidelines for organizing State and area-wide community health planning activities, but fails to rigorously define planning as a concept (*2*).

Our basic purposes in this paper, therefore, are to offer a definition of planning, to suggest ways of looking at objectives in comprehensive health planning, to differentiate among different forms and methods commonly encountered in health planning today, and to summarize some of our experiences in the CASP program of 21 community health self-studies which illus-

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trate planning concepts and provide operational insights for those engaging in elements of comprehensive community health planning.

### What Is Planning?

It is simple enough to say that planning will solve the many problems with which we are confronted; it is much more difficult to realize a goal of problem resolution. What do we mean by planning and, more specifically, by comprehensive community health planning? Literally, planning is an attempt at rationally calculated action to achieve a goal while, at the same time, maximizing efficiency. To most people, planning is simply the development of a plan—a blueprint—of what "ought" to be done based on all facts of the situation.

This is especially true in industry. An automobile company, for example, plans how many vehicles and what types to manufacture and at what price to offer them to the public. Planning in this case is based on estimates of cost and demand market factors, objectives and resources of the company, and so forth.

Some health workers try to apply this rational, economic model to the health world by techniques such as operations research; planning, programing, and budgeting; or cost benefit analysis, in order to maximize the ratio between inputs into the health system and outcomes of it. These techniques are useful, but comprise only a part of planning. Whereas these techniques usually start with a statement of objectives or allocation of resources and end with a decision for a course of action from among several alternatives, complete planning starts from a cultural value base and culminates in action.

Techniques which are useful to planning in one situation may not be appropriate in another. Operations research, for example, may be useful in an administratively monolithic system, but it is relatively less useful in a pluralistic system characterized by many autonomous groups and agencies working within the same domain, often with conflicting values and goals.

There are some fundamental differences between the kinds of planning exemplified by the automobile industry or by the individual who plans a blueprint for his home and social and health planning. First, in the health field there is a basic difference in terms of the social structure of the subsystem—a pluralistic system containing many organizations, each having a part in health care but lacking a single superordinate power. In industry, a company has a monolithic administrative system in which the parts relate to the corporate board of directors and the management. Second, this pluralistic health system gives rise to considerable disagreement as to goals—unlike the more simple and direct profit motive of industry. An even more fundamental difference may lie in who is making the decisions. In industry and in the house blueprint, plans are made by one for himself or for his own group—family or business. It is different when one plans for someone else, as in the case of a community group planning health services for others in the community, regardless of the laudable motives of the planners or the wisdom of their plans.

Dimensions of planning may also vary in purpose, subject matter, scope, depth, formality, time, area covered, and so forth. However, the basic elements of the planning process are applicable to all dimensions.

The following definition of planning is generically applicable to all methods of planning: Planning is a decision making process, culminating in action, in which 10 sets of decisions and action are made, starting from a definition of values, through definitions of problems, priorities, objectives, and activities, and culminating in action implementation and evaluation.

The 10 decisions in planning are made consciously or subconsciously by planners and can be viewed as follows:

*Decision 1:* The ideal, based on the cultural value system, is described. All planning starts with values held by our culture. For example, we agree that infant mortality is bad and we take steps to lower the mortality rate. But why do we do this? Some value instilled within us tells us infant mortality is bad and we should not ignore it; another culture might not have the same view. This first decision, about values and value systems, is often not recognized in health planning, yet it is the genesis of planning, giving us the "shoulds" upon which we base our work.

*Decision 2:* For the parameters identified in decision 1, estimates are made of the conditions

that would exist at some future time in the absence of intervention. Hence, planning is future-oriented in that we are deciding not about present problems exclusively, but anticipating future ones.

*Decision 3:* Perceived problems are identified by estimating the discrepancy between results of decisions 1 and 2. Using infant mortality as an example, the extent of the problem is determined by the difference in the magnitude of the estimated future death rate and that which we ideally want. If we estimate that the infant death rate would be 25 per 1,000 in 10 years without intervention, and the ideal is 10 per 1,000, the discrepancy is 15 per 1,000.

*Decision 4:* Priorities are set based on (*a*) perceptions of need, identified through decision 3, and (*b*) constraints imposed by the plausibility of intervention—lack of resources or technology or both.

For example, we may think death is bad, but nevertheless inevitable. Although we cannot eliminate death, we may believe we can modify somewhat the circumstances of death—the conditions under which a person dies or time of death. In recent years, communicable diseases have diminished as a cause of death and chronic illnesses have replaced them. The place of death has been largely changed from the nursery to the nursing home through disease control programs. Thus, the fourth decision in the planning process requires establishment of priorities based on the problems perceived as the result of the previous three decisions. Of course, the assumption is that allocations must be made among scarce resources, necessitating priority setting. If resources were unlimited there would be no need to set priorities.

*Decision 5:* Objectives are set, based on the decided priorities. These objectives are descriptions of the conditions we intend to result from our planning efforts. Again, constraints will limit objectives. For example, although we might like to eliminate infant mortality, we realize this is impossible; therefore, we set our objectives more realistically to reduce infant deaths to some specified level which is adjudged to be "tolerable." The objectives set will be less than ideal, but somewhat better than they would have been without our planned intervention.

*Decision 6:* Activities are enumerated which are believed will result in achievement of our objectives, specified in decision 5. Here we must distinguish the objectives, conditions of people or the environment toward which we are aiming, from activities—the methods by which we achieve the objectives. This distinction, discussed in detail in a recent article on program evaluation (*3*), is equally crucial to the planning process.

*Decision 7:* A course of action is selected from among alternate courses open to us that is believed will lead to our objectives. Several courses of action can be taken—different activities or different paths to the goals. Among these paths, we must choose which we desire—a critical step in the planning process.

*Decision 8:* Resources are allocated to allow us to undertake the program activities. The greatest plan without a budget or tangible resources is meaningless; hence, resources are required and must be allocated.

*Decision 9:* Resources are mobilized for action implementation. Having the resources available to conduct a program is different from mobilizing them into an effective and efficient program. This is especially true of the health field where money is only one kind of resource necessary for organization and delivery of health services. Equally important are the recruitment of personnel (paid or volunteer), enlisting the cooperation of the people necessary for carrying out the program (including the clients themselves), and the actual organization of the details of the program activities.

*Decision 10:* Activities are implemented and evaluation undertaken as the end product in the planning process. In the final analysis, action that results from the development of plans constitutes the payoff for community health services and the improved health of the populace. Members of the Community Action Studies Project of NCCHS considered action so important in this process that they used the term "action-planning" to emphasize the concept. Realistically, community action consists of a series of decisions to cooperate on the part of the several agencies whose support and activities are crucial to the program.

To summarize at this point, planning is conceived as a continuous decision making process in which 10 decisions and actions are made,

whether consciously or not. Starting from a cultural value base, conditions in the future are estimated, problems are identified, priorities are determined, objectives are set, a course of action is chosen from among alternatives, resources are allocated, resources are organized and mobilized, and action is taken to implement the decisions and evaluate their success or failure.

We do not propose that each step in the planning process is completed in the exact sequence described; continual interaction among the various decisions takes place. The objective that the U.S. infant death rate shall be no higher than 15 per 1,000 live births by 1980 is not specified before considerable thought is given to activities and resources. However, there is logic in the sequence because certain decisions must precede others. For example, the specific activities to be undertaken (what, when, where, how, and by whom) are not appropriately formulated until after objectives are specified.

Having defined planning, we may now state the primary objective of planning—that the health status of the public approaches the ideal envisioned in decision 1, and that decisions be made at each step in the planning process in a manner that attains that objective. The hypothesis of those who advocate planning is that better decisions result with planning than without it. Implicit in this reasoning is lack of complacency with the current state of affairs.

### Methods of Planning

Thus far we have discussed a definition of planning only as a decision making process which leads to performance of activities to accomplish objectives. Now we turn to the philosophy and methods of planning. Who is to control the planning effort and what kinds of data are to be used in identifying problems and setting objectives and activities? We recognize that the who and what of planning may be different at different levels of decision making and in different social structures. We have already discussed differences in internal planning in industry or an agency as compared with communitywide planning and potential appropriateness of different methods. In a self-contained, administrative situation a highly rational method of planning may be appropriate. If many autonomous agencies within a community are planning jointly, there is reasonable question as to the advisability of the same systems analysis approach to planning.

A planning group may restrict its attention to decisions 1 through 4, leaving decisions about objectives, activities, and subsequent planning steps to operating agencies. Or, different groups may make decisions at the same point in the planning process but at different levels of detail or specificity. For example, a planning group may decide that reducing infant mortality is a general communitywide objective; thereupon, various operating agencies decide on specific objectives—a particular magnitude of reduction in the infant death rate, perhaps in a particular subgroup of the population.

In speaking of comprehensive community health planning, the unit with which we are dealing is the community, which can be thought of as the health and medical trade area or the community of decision—that area facing common problems and interdependencies. The question, then, is how best to sustain a realistic, viable planning process which has a high chance of success in effecting appropriate decisions and in achieving action on those decisions.

How, for example, can we acquire sufficient information for aiding the decision making process on a community level? From his experience with a health study in Newark, N.J., Harry W. Jones, an insurance executive, commented in a personal communication:

> They (data) have to be supplemented and interpreted. In every community there are intelligent and informed non-professional people who know a great deal more than our formal statistics can ever reveal. . . . Action is the crux of the problem and should have the greatest emphasis . . . and action in my opinion is far more likely to occur with respect to reasonably attainable goals set by well-informed people even though they are not wholly expert and some of their data are no more than an intelligent sense of smell.

In his comments, Mr. Jones pointed up several pertinent considerations in community planning. First, nonprofessionals know a great deal about their community and can be instrumental in getting action if properly motivated. Second, statistical data which can be useful are scarce, leaving a statistical systems approach in jeopardy if we rely on hard data alone as a basis for planning.

This brings up an interesting point in planning considerations. Who does know what the community needs and what the problems are? Public health workers usually hear about the professionally defined "health needs" of a community, based on professional value systems. On the other hand, we hear of health service demands of the people, which may be similar to or different from those defined by the professional. In community health planning, we must resolve how the needs and demands are to be determined and by whom. How we resolve these matters will influence our mode of planning.

The method we recommend as realistic and workable, overcoming many of the problems mentioned heretofore, can be termed the "community organization" approach in planning. Each person brings into a situation a frame of reference based on his entire background of information and experience. The subjectively defined needs or wants of each person, based on his value system and experiences, are as rational as statistical data are to the researcher. If representatives of the health community (in the regional health and medical trade area sense of the word) are included in the decision making process, we can integrate the professionally defined needs with the public demands, using every source of information to arrive at decisions. Here, the group dynamics theory of Lewin suggests that a representative group of people affected (professionals and laymen) can work toward community consensus (or at least majority decision) as to problem identification, needs, and realistic courses of action. Such consensus of persons representing different interest groups will likely reflect more accurately the total community situation than would the conclusions of any one person or specialized group. Furthermore, the resultant plan is more likely to be implemented.

The community organization approach has another virtue—the management of conflict. Inevitably when several organizations are competing for funds and attention, there will be differences of opinion about what the needs are and how they can best be met. Even though many of the overall objectives are agreed on, many intermediate objectives and the "how to do it" (activities) are not so easy to resolve. With so many different organizations, having conflicting individual and corporate goals, diverse histories, traditions, and needs, there is bound to be legitimate difference of opinion, different interpretation of the same events, and different definitions of needs and suggestions for resolving them. The community organization approach brings to light such differences and encourages management of conflict through the planning mechanism.

Through the community organization approach, the planning process can be conceived of as the following two processes:

1. A political process of decision making, conflict resolution, and achievement of a degree of consensus regarding allocation of scarce resources, plans of action, and the important functions of development of support for resulting program plans.

2. An educational process whereby those involved in planning learn more about health problems, gain insights into the complexities of community health affairs, and change their attitudes, perceptions, and behaviors as a result of their "action." Such experience consists of identifying problems, gathering data, and having discussions with others in the community who have similar or different views, and it eventually leads to setting goals and planning action. Simply, this is the educational concept of learning by doing.

The community organization approach allows for considerable flexibility and allows professionals and laymen to participate in a democratic process, using whatever information may be available to the group.

### The CASP Experience

While the National Commission on Community Health Services was operating during 1962–66, we in the Community Action Studies Project had the opportunity to work with 21 communities throughout the nation, representing different sizes and different characteristics, that conducted self-studies of their health services. Some of these communities are continuing their study and action programs. Based on our observations of the studies, what the study leaders told us, and through a series of independent research projects aimed at understanding the dynamics of community health action, CASP identified a five-step sequence of events

that these planning groups experienced in the decision making process which we have discussed.

*Organization.* The ultimate success or failure of any planning process depends on the strength of the organization doing the planning. If adequate representation of the community is not achieved, if those in decision making positions (in nonhealth as well as health fields) are not meaningfully involved, if there is not adequate opportunity for gathering and interpreting relevant facts along with sufficient democratic discussion before making the decisions, then the planning efforts will likely be less than successful—in fact they may be deleterious. Getting (*4*) showed that it is possible to involve leading decision makers in the community, as his group did in the Michigan Community Health Services Study. Likewise, as a result of the CASP process analysis efforts, Wilson (*5*) identified the influence of the mix of business, political, and professional leaders in the action-planning efforts as a correlate to success in planning. The absolute necessity for strong organization cannot be overemphasized in comprehensive community health planning.

*Factfinding.* The second step is the collection and use of adequate, relevant, and accurate facts upon which to base decisions. As we indicated earlier, these facts may come from a variety of sources in a variety of forms. Some of the "facts" with which a group deals may be the subjective feelings of the people who make up the community, the political and economic situations, and the attitudes and motivations of the community residents (obviously including those of the professionals). It would indeed be foolish to ignore any information that can be brought to bear on the problems. Within the context of our emphasis on development of objectives in the planning process, it is important that factfinding efforts should attempt first to determine the true extent of the health problems—the incidence and prevalence of disease and disability—as a baseline from which to set realistic objectives and to decide on the kinds of activities which must be developed to correct the deficiencies. One way to consider facts about community health services is contained in the American Public Health Association's "A Self-Study Guide for Community Health Action-Planning" (*6*) which was developed by the NCCHS.

*Analysis and interpretation.* After the facts have been collected and organized logically, they must be analyzed and interpreted in the light of community values, perceived needs, readiness of the community to act, and resources available. Undoubtedly, some members will disagree as to the meaning of the data and what to do about conditions observed. For every suggested course of action, there will be alternate courses that may be just as good. During this phase of the planning process the educational impact of the situation emerges, and the political process of conflict resolution—of give and take—and of decision making among alternate feasible courses of action takes place at the fullest.

*Goal setting.* Specific goals and priorities for action must be developed and the planning group must be specific as to with whom the responsibility lies for initiating action and the time frame (immediate or long range). In an analysis of community health studies conducted during the past decade (*7*), we in CASP discovered, to our chagrin, that many groups never progress beyond the primary stage of identifying needs. Too often they do not identify appropriate corrective or preventive action, nor do they specify the agencies or people who should initiate action. The result is that everybody's business becomes nobody's business, and the study report gathers dust on the library shelf—a waste of time, money, and energy of those who participated.

*Action and evaluation.* Although some people believe that planning does not have an action component, we believe that action is so much a part of the planning process that it cannot be ignored. In fact, we in CASP wrote action into the name of planning when we coined the term "action-planning" (*1*). As the planning group sets the overall objectives and specific action objectives, it also should follow through with an action plan which outlines the objectives, how they can be achieved, by whom and when, plus built-in evaluation to guide in measuring the accomplishment of the objectives. However, since communities and their people and institutions are dynamic and constantly changing, no single plan or blueprint will be applicable to all, nor will a plan remain relevant for an ex-

tended period. As soon as a plan has been adopted, it will be slightly (or even moderately) outdated because of ever-occurring changes. Although there is merit in writing the objectives down as benchmarks, the mere specification of a plan does not mean that the planning cycle is completed. This is why we stress that planning is a flexible, continuous process of decision making and action which often deals with a concept of incremental changes rather than the concept of a static master plan.

### Benefits of Planning

The ultimate question regarding any concept or method of planning is: Will it work? Skeptics, who doubt the feasibility of community planning in health or in any other field, cite the self-interests of actors in the health field; that interest groups carve out domains and guard them "like fiefdoms." Some persons doubt that the coordination and cooperation so essential to comprehensive action-planning can function effectively in a pluralistic, democratic society. Some of these critics advocate centralized control as a precondition to achieve action, and they invariably call for more scientifically rational decision making coupled with legal controls commensurate with effecting the plans.

We cannot disagree with the critics about the pluralistic, fragmented patterns within the present-day health system, nor can we ignore the many conflicts and special vested interests. Nor do we disagree that more rational decision making is in order. However, some critical philosophical and pragmatic questions must be raised. What is the alternative to the community organization approach? If the alternative is centralization, then who is to control the planning process? Who is to make the binding decisions? How are we to achieve cooperation and involvement of users and providers of services without encountering disabling resistance to change? Do we really know enough about what we are recommending and the consequences at any one point in time to make sudden radical changes?

Will the community organization approach to comprehensive community health planning work? Based on nearly 4 years of recent experience in working with 21 communities in the CASP program, we say, "Yes."

Some characteristics of the planning process are seen as benefits by some people and limitations by others, however. Following are five such characteristics which we should recognize and cope with in the planning process:

1. Realistic planning depends on wide representation of people in the community. Obviously it is impossible to involve everybody in the planning, therefore there must be a selection of participants to represent the whole.

2. As a result of planning, there will be some loss of autonomy and sovereignty even though the decision making process may be democratic. This can cause great concern among the participating organizations.

3. If decisions are implemented which limit the practice of laissez-faire, someone will be affected; there will be at least some restraint and loss of individual freedom for the common good. These inevitable changes and restraints will solve some problems, but undoubtedly will introduce different ones.

4. Planning will change certain organizational configurations and will realine some of the traditional power structure relationships. The result will be that some people will have been displaced by the planning process.

5. Planning, by definition, works from a value base. There are inevitable value conflicts in our heterogeneous society. The planning process will heighten awareness to conflicts and may lead to schisms and antagonisms among health workers.

During the latter days of the commission's work, the leaders of the 21 community studies (laymen and professionals) were asked to review the results of their experiences—what they had done, how they had handled their respective planning efforts, what they would do differently if they had another chance, what they accomplished, and how they would advise others who were contemplating a similar planning endeavor. The following are samples of their responses.

First, in virtually every study, it was possible to define a multijurisdictional health service community and to achieve functional regional planning relationships. The community typically encompassed several towns, counties, and even States; thus groups were able to plan as a regional entity, subsequently integrating overall policies into separate administrative programs.

Many communities took approximately 1 year to achieve organizational consensus to engage in a planning effort (this was before P.L. 89–749) and another 2 years from the organizational phase until the groups had arrived at the point of publishing a plan—time factors paralleled size of community, with the more complex communities obviously having more delays, since there were more individuals and agencies to involve and coordinate. Communities of different sizes had different kinds of problems. The large communities had difficulty in identifying leadership groups as they were often fragmented and their leaders usually lived in the suburbs rather than in the central city. The small communities had difficulties in locating sufficient personnel and data to engage in planning. Yet in such situations, paths were inevitably found and major difficulties were overcome.

Two kinds of goals were achieved:

1. Tangible, brick and mortar goals were achieved—an Oklahoma county is now developing a county health department (the result of voting a mill levy) among other achievements. A Tennessee community voted, by a margin of 4 to 1, to pass a 1 cent sales tax, half to be devoted to health and welfare and half to education as a result of concerted community concern and action resulting from the planning efforts. A southern metropolis is now fluoridating its water supply and providing dental care for its indigent population. Another community has blocked the efforts of a few persons to construct an unneeded pediatric hospital. Laws regarding mental commitment were modernized in one State; this action was attributed to pressures resulting from the planning efforts of two communities. These are a few of the tangible results within the first year of implementation of planning reported to CASP.

2. A second kind of achievement cannot be described in the brick and mortar terms, but nevertheless represents significant accomplishment from the point of view of the health leadership. This accomplishment includes (*a*) coordination of services and planning—"people are now talking to each other for the first time," (*b*) community awareness of health problems and needs, developing new and enlightened concern in a wider segment of the population and consequent development of more broadly based community support, and (*c*) development of regional planning mechanisms and the requisite interjurisdictional relationships for planning on a long range, continuing basis.

In our experience, many community health needs and problems on which action was initiated in the 21 communities were not unknown to health leaders at the time planning was started. The planning mechanism became a vehicle for articulation of perceived needs by laymen and professionals, often for the first time. This is a crucial step in the readiness of a community to take appropriate health action, according to results of our study of community readiness. Researchers Goldstein and Agger (*8*) visualized readiness of a community to take action as being composed of a triad of (*a*) leadership awareness, (*b*) citizen awareness, and (*c*) existence of a mechanism in which awareness and demands can be brought together and resolved in a constructive manner.

Of course, planning will not automatically insure success or initiate action. In all communities with which we worked, there are numerous goals yet to be realized; there have been disappointments, yet none of their experiences can be classified as complete success or complete failure.

Major issues, conflicts, and controversies faced, as reported by study leaders, included (*a*) apprehension about the aims, goals, and reasons for planning resulting partly from a fear of control, fear of loss of agency autonomy, and lack of perception of any dysfunction in present health programs, (*b*) the issue of communitywide planning per se, in which basic questions were raised about governmental and private relationships and responsibilities along with resistance to planning and sharing data necessary for decision making, (*c*) struggles for power and influence resulting from personality conflicts, political fears about possible findings, special interests, and acceptability of majority rule on specific proposals, and (*d*) lack of interest—complacency with the status quo was an issue in some places.

How were these conflicts overcome and a favorable climate for implementation established? Three primary strategies were used, (*a*) involvement along two axes—involving de-

cision makers in the planning efforts and including representatives of geographic areas, (*b*) extensive use of the mass media to interpret the activities and findings of the planning group, and (*c*) personal persuasion and interpretation of the purposes and activities of the planning process by those participating.

Among the primary factors considered responsible for successful planning was the involvement of the "right" people in the process. Organization and structure of the planning group, which facilitated this involvement and appropriate decision making, was mentioned as another key element, as was obtaining the cooperation of various agencies and groups and a wide range of citizen support. The specification of objectives, narrowing broad objectives into workable programs, was considered another factor facilitating achievement.

## Discussion

Several themes became apparent from the work of CASP and the commission as a whole.

1. No single agency or group at local, State, regional, or national level has exclusive domain and unfettered responsibility for health in a community. Many groups have legitimate claim to health programs and valuable contributions to make. The key, therefore, is to plan and develop health programs within a community on a cooperative, coordinated, logical basis in order to minimize overlap and duplication of efforts and to plug any existing gaps in services.

2. Health is a total community affair. Local people have great potential for developing realistic solutions to their problems if they organize on a community level, involve a wide range of the citizenry, and seek advice and counsel from many sources within and outside the community.

3. Local, State, and national bodies must work as partners with communities in helping them to achieve their health goals—we call the relationship "partners in progress." Too long we have called the Federal Government "they" and the local government "we." All levels of government, private enterprise, and voluntary agencies are interdependent and must work together for the common good. Each group has a unique contribution to make in this partnership.

4. Health problems are no respecters of artificial or arbitrary political jurisdictional boundaries. Solving current health problems requires a coordinated approach, which transcends traditional boundary lines and is organized on a geographic basis comparable to the magnitude of the problem and sufficient resources. Usually one town, city, or county does not have the resources to cope with health needs if it acts alone, whereas several working together can effect solutions. The area we are suggesting has variously been called the "health and medical trade area" or "community of solution."

5. Regional action-planning is a prerequisite to logical development of community health services. The action-planning process consists of a number of identifiable steps, previously mentioned. It is important that action-plans are implemented, and that study reports and plans are not shelved.

6. Health is not an isolated community issue; health is intertwined with issues such as economic development, education, transportation, welfare, race relations, and other concerns. One cannot discusss health matters without considering these other subject areas, since health is an aspect of each of these issues, and vice versa. Therefore, health should be studied within the context of total community development.

## Summary

Community health planning is a 10-step decision making process which is both political and educational. It is a process by which problems, objectives, and program activities are articulated, resources are allocated, and support is developed to implement agreed-on programs. Its outcome is action to implement the plans accruing from the process. Participants in the process learn by doing—by discovering and assimilating facts, by analyzing and interpreting them in light of the community situation, and by democratically discussing and ultimately deciding what to do about deficiencies discovered. The planning process is a way to integrate needs, as professionally defined, with demands, as defined by consumers of services, and to balance the various forces in the community into an integrated whole. Differences and conflicts which emerge in community health planning can be

managed through political processes, using planning data as a common baseline of understanding.

#### REFERENCES


(1) National Commission on Community Health Services: Action-planning for community health services (a report of the Community Action Studies Project). Public Affairs Press, Washington, D.C., 1967.

(2) Subcommittee on Comprehensive Health Care Planning, Program Area Committee: Guidelines for organizing State and area-wide community health planning. Amer J Public Health 56: 2139–2143, December 1966.

(3) Deniston, O. L., Rosenstock, I. M., and Getting, V. A.: Evaluation of program effectiveness. Public Health Rep 83: 323–335, April 1968.

(4) Getting, V. A.: Michigan community health services study. Public Health Rep 82: 925–932, October 1967.

(5) Wilson, R. W.: Process analysis: Community structure and health action. Public Affairs Press, Washington, D.C., 1968.

(6) American Public Health Association: A self-study guide for community health action-planning. New York City, 1967, 2 vols.

(7) Swanson, B. E.: A retrospective analysis of community health studies. Report prepared for National Commission on Community Health Services, 1966.

(8) Goldstein, M. N., and Agger, R. E.: Community readiness: A causal analysis. Interim report prepared for National Commission on Community Health Services, 1966.


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